AMENDED IN SENATE MAY 12, 2003

AMENDED IN SENATE APRIL 29, 2003

AMENDED IN SENATE APRIL 3, 2003

SENATE BILL No. 228

Introduced by Senator Alarcon
(Coauthor: Senator Murray)

February 13, 2003

An act to amend Sections 62.5, 4603.2, and 5402 of, to add Section 3823 to, to repeal Sections 5307.2 and 5307.21 of, and to repeal and add Section 5307.1 of, the Labor Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

SB 228, as amended, Alarcon. Workers' compensation: fraud: fee schedules.

(1) Existing law establishes the Workers' Compensation Administration Revolving Fund as a special account in the State Treasury.

Under existing law, money in the fund, which is made up of employer assessments, may be used, upon appropriation by the Legislature, for administration of the workers' compensation program, and may not be used for any other purpose except as determined by the Legislature.

Existing law requires 80% of the costs of administration of the workers' compensation program to be paid for from the General Fund, with the remaining 20% to be paid for from employer assessments, which are deposited into the Workers' Compensation Administration Revolving Fund.

This bill would provide that if the Budget Act or any other statute alters the funding methodology of the fund so that employer

assessments account for a greater proportion of funding than appropriations from the General Fund, unless expressly prohibited, a sufficient portion of these funds shall be dedicated to implement the fraudulent claim reporting and medical fee schedule reporting provisions contained in this bill, to permit the adoption of specified staffing and clerical employee recommendations, and to enable the development of a cost-efficient electronic adjudication management system.

(2) Existing law makes it a crime for any person to make false or fraudulent statements, or take certain other actions, with respect to any claim under the workers' compensation system.

This bill would require the Administrative Director of the Division of Workers' Compensation, in coordination with specified persons or entities, to develop procedures to receive and review reports of medical billing fraud and to report these violations of law to specified persons and entities. It would require certain parties to report claims believed to be fraudulent to the administrative director in accordance with these procedures.

(3) Existing law requires the administrative director to adopt an official medical fee schedule, which shall establish reasonable maximum fees paid for medical services provided under the workers' compensation laws. Existing law imposes various requirements concerning the official medical fee schedule.

Existing law requires the administrative director to adopt by July 1, 2003, and revise no less frequently than biennially, an official pharmaceutical fee schedule.

Existing law additionally provides that the administrative director has the sole authority to develop an outpatient surgery facility fee schedule for services not performed under contract.

This bill would delete these fee schedule requirements. It would, instead, prohibit charges under this medical fee schedule from exceeding 120% of the fee prescribed for the same item in the applicable Medicare payment system, or, with regard to pharmacy services and drugs, 100% of the fee prescribed by the applicable Medi-Cal payment system.

This bill would require that, if no Medicare or Medi-Cal payment system applies, as appropriate, the administrative director establish maximum fees, subject to the limitation that the maximum fees paid do not exceed 120% of the fees paid by Medicare for services that require comparable resources or, with regard to pharmacy services and drugs,

100% of the fees paid by Medi-Cal for pharmacy services or drugs that require comparable resources.

This bill would require that, within the limits established by the bill, the rates or fees established by the medical fee schedule be adequate to ensure a reasonable standard of services and care for injured employees.

The bill would also impose maximum fee limitations applicable until the adoption of the fee schedule required pursuant to the bill.

(4) Existing law requires an employer to provide payment to a physician who has provided medical treatment to an injured employee as part of his or her workers' compensation benefits within 60 days after the employer receives a billing statement and other documentation, except as prescribed.

This bill would reduce this period to 45 days, and would make conforming changes.

(5) Existing law provides that, if liability is not rejected by the employer within 90 days after the date a claim for workers' compensation benefits is filed by an employee, the injury shall be presumed compensable.

This bill would reduce this period to 60 days.

(6) This bill would make its provisions operative only if SB 229 is enacted during the 2003 portion of the 2003–04 regular session.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 62.5 of the Labor Code is amended to read:

62.5. (a) The Workers' Compensation Administration Revolving Fund is hereby created as a special account in the State Treasury. Money in the fund may be expended by the department, upon appropriation by the Legislature, for the administration of the workers' compensation program set forth in this division and Division 4 (commencing with Section 3200), other than the activities financed pursuant to Section 3702.5, and may not be used for any other purpose, except as determined by the Legislature.

(b) The fund shall consist of assessments made pursuant to this section. Costs of the program shall be shared on a proportional basis between the General Fund and employer assessments. The

General Fund appropriation shall account for 80 percent, and employer assessments shall account for 20 percent, of the total costs of the program.

(c) Assessments shall be levied by the director upon all employers as defined in Section 3300. The total amount of the assessment shall be allocated between self-insured employers and insured employers in proportion to payroll respectively paid in the most recent year for which payroll information is available. The director shall promulgate reasonable rules and regulations governing the manner of collection of the assessment. The rules shall require the assessment to be paid by self-insurers to be expressed as a percentage of indemnity paid during the most recent year for which information is available, and the assessment to be paid by insured employers to be expressed as a percentage of premium. In no event shall the assessment paid by insured employers be considered a premium for computation of a gross premium tax or agents' commission.

(d) If the Budget Act or any other statute alters the funding methodology set forth in this section for the Workers' Compensation Revolving Fund so that employer assessments account for a greater proportion of funding than the General Fund, unless expressly prohibited by statue, a sufficient portion of those funds shall be dedicated to implement the fraudulent claim reporting and medical fee schedule reporting provisions contained in Sections 3823 and 5307.1, to permit the adoption of the staffing and clerical employee retention recommendations in the study prepared by RAND and the California Commission on Health and Safety and Workers' Compensation, dated 2003, concerning the judicial functions of the Workers' Compensation Appeals Board, and to enable the development of a cost-efficient electronic adjudication management system.

SEC. 2. Section 3823 is added to the Labor Code, to read:

3823. (a) The administrative director shall, in coordination with the Bureau of Fraudulent Claims of the Department of Insurance, the Medi-Cal Fraud Task Force, and the Bureau of Medi-Cal Fraud and Elder Abuse of the Department of Justice, develop procedures to do both of the following:

(1) Receive and review reports of medical billing fraud.

(2) Report these violations of law to the appropriate licensing body, if applicable, and to the district attorney of the county where the offenses were committed.

(b) Any insurer, self-insured employer, third-party administrator, workers' compensation administrative law judge, audit unit, attorney, or other person that believes that a fraudulent claim has been made by any person or entity providing medical care, as described in Section 4600, shall report the apparent fraudulent claim in the manner prescribed by the administrative director pursuant to subdivision (a).

SEC. 3. Section 4603.2 of the Labor Code is amended to read:

4603.2. (a) Upon selecting a physician pursuant to Section 4600, the employee or physician shall forthwith notify the employer of the name and address of the physician. The physician shall submit a report to the employer within five working days from the date of the initial examination and shall submit periodic reports at intervals that may be prescribed by rules and regulations adopted by the administrative director.

(b) Payment for medical treatment provided or authorized by the treating physician selected by the employee or designated by the employer shall be made by the employer within 45 days after receipt of each separate, itemized billing, together with any required reports and any written authorization for services that may have been received by the physician. If the billing or a portion thereof is contested, denied, or considered incomplete, the physician shall be notified, in writing, that the billing is contested, denied, or considered incomplete, within 30 working days after receipt of the billing by the employer. A notice that a billing is incomplete shall state all additional information required to make a decision. Any properly documented amount not paid within the 45-day period shall be increased by 10 percent, together with interest at the same rate as judgments in civil actions retroactive to the date of receipt of the bill, unless the employer does both of the following:

(1) Pays the uncontested amount within the 45-day period.

(2) Advises, in the manner prescribed by the administrative director, the physician, or another provider of the items being contested, the reasons for contesting these items, and the remedies available to the physician or the other provider if he or she disagrees. In the case of a bill which includes charges from a

hospital, outpatient surgery center, or independent diagnostic facility, advice that a request has been made for an audit of the bill shall satisfy the requirements of this paragraph.

If an employer contests all or part of a billing, any amount determined payable by the appeals board shall carry interest from the date the amount was due until it is paid.

An employer's liability to a physician or another provider under this section for delayed payments shall not affect its liability to an employee under Section 5814 or any other provision of this division.

(c) Any interest or increase in compensation paid by an insurer pursuant to this section shall be treated in the same manner as an increase in compensation under subdivision (d) of Section 4650 for the purposes of any classification of risks and premium rates, and any system of merit rating approved or issued pursuant to Article 2 (commencing with Section 11730) of Chapter 3 of Part 3 of Division 2 of the Insurance Code.

(d) (1) Whenever an employer or insurer employs an individual or contracts with an entity to conduct a review of a billing submitted by a physician or medical provider, the employer or insurer shall make available to that individual or entity all documentation submitted together with that billing by the physician or medical provider. When an individual or entity conducting a bill review determines that additional information or documentation is necessary to review the billing, the individual or entity shall contact the claims administrator or insurer to obtain the necessary information or documentation that was submitted by the physician or medical provider pursuant to subdivision (b).

(2) An individual or entity reviewing a bill submitted by a physician or medical provider shall not alter the procedure codes billed or recommend reduction of the amount of the bill unless the documentation submitted by the physician or medical provider with the bill has been reviewed by that individual or entity. If the reviewer does not recommend payment as billed by the physician or medical provider, the explanation of review shall provide the physician or medical provider with a specific explanation as to why the reviewer altered the procedure code or amount billed and the specific deficiency in the billing or documentation that caused the reviewer to conclude that the altered procedure code or amount

recommended for payment more accurately represents the service performed.

(3) Unless the physician or medical provider has billed for extraordinary circumstances related to the unusual nature of the medical services rendered pursuant to subdivision (b) of Section 5307.1, this subdivision shall not apply when a bill submitted by a physician or medical provider is reduced to the amount or amounts specified in the official medical fee schedule, preferred provider contract, or negotiated rate for the procedure codes billed.

(4) The appeals board shall have jurisdiction over disputes arising out of this subdivision pursuant to Section 5304.

SEC. 4. Section 5307.1 of the Labor Code is repealed.

SEC. 5. Section 5307.1 is added to the Labor Code, to read:

5307.1. (a) The administrative director, after public hearings, shall adopt and revise periodically, an official medical fee schedule that shall establish reasonable maximum fees paid for medical services, drugs and pharmacy services, health care facility fees, home health care, and all other treatment, care, services, and goods described in Section 4600 and provided pursuant to this section in accordance with the fee-related structure and rules of the relevant Medicare and Medi-Cal payment systems, provided that employer liability for medical treatment, including issues of reasonableness, necessity, frequency, and duration, shall be determined in accordance with Section 4600. Effective January 1, 2004, and continuing until such time as the administrative director has adopted an official medical fee schedule in accordance with the structure and rules of the relevant Medicare payment systems, except for the components listed in subdivision (k), maximum reasonable fees shall be 120 percent of fees prescribed in the relevant Medicare payment system, except that for pharmacy services and drugs, the maximum reasonable fees shall be 100 percent of fees prescribed in the relevant Medi-Cal payment system. Upon adoption by the administrative director of an official medical fee schedule pursuant to this section, the maximum reasonable fees paid shall not exceed 120 percent of fees prescribed in the Medicare or Medi-Cal payment system. Pharmacy services and drugs shall be subject to the requirements of this section, whether furnished through a pharmacy or dispensed directly by the practitioner pursuant to subdivision (b) of Section 4024 of the Business and Professions Code.

(b) In order to comply with the standards set forth in subdivision (d), the administrative director may adopt different conversion factors, diagnostic related group weights, and other factors affecting payment amounts from those used in the Medicare payment system provided no fee paid exceeds 120 percent of the fee paid for the same item in the relevant Medicare payment system.

(c) The maximum facility fee for services performed in an ambulatory surgical center may not exceed the fee paid by Medicare for the same services performed in a hospital outpatient department.

(d) If the administrative director determines that a medical treatment, facility use, product, or service is not covered by a Medicare payment system, the administrative director shall establish maximum fees for that item, provided that the maximum fee paid shall not exceed 120 percent of the fees paid by Medicare for services that require comparable resources. If the administrative director determines that a pharmacy service or drug is not covered by a Medi-Cal payment system, the administrative director shall establish maximum fees for that item, provided, however, that the maximum fee paid shall not exceed 100 percent of the fees paid by Medi-Cal for pharmacy services or drugs that require comparable resources.

(e) Prior to the adoption by the administrative director of a medical fee schedule pursuant to this section, for any treatment, facility use, product, or service not covered by a Medicare payment system, or, with regard to pharmacy services and drugs, for a pharmacy service or drug that is not covered by a Medi-Cal payment system, the maximum reasonable fee paid shall not exceed the fee specified in the official medical fee schedule in effect on December 31, 2003.

(f) Within the limits provided by this section, the rates or fees established shall be adequate to ensure a reasonable standard of services and care for injured employees.

(g) (1) Notwithstanding any other provision of law, the official medical fee schedule shall be adjusted to conform to any relevant changes in the Medicare and Medi-Cal payment systems no later than 60 days after the effective date of those changes, provided that all of the following conditions are met:

(A) The annual inflation adjustment for physician and other practitioner services is determined solely by the percentage increase in the Medicare Economic Index for the 12 months ending March 31 of the preceding calendar year.

(B) The annual inflation adjustment for facility fees for inpatient hospital services provided by acute care hospitals and for hospital outpatient services shall be determined solely by the estimated increase in the hospital market basket for the 12 months beginning October 1 of the preceding calendar year.

(C) The annual inflation adjustment for facility fees for inpatient hospital services provided by hospitals excluded from the Medicare prospective payment system for acute care hospitals shall be determined solely by the estimated increase in the hospital market basket for excluded hospitals for the 12 months beginning October 1 of the preceding calendar year.

(2) The administrative director shall determine the effective date of the changes, and shall issue an order, exempt from the Administrative Procedure Act, informing the public of the changes and their effective date. All orders issued pursuant to this paragraph shall be published on the Internet Web site of the Division of Workers' Compensation.

(3) For the purposes of this subdivision, the following definitions apply:

(A) ''Medicare Economic Index'' means the input price index used by the Centers for Medicare and Medicaid Services to measure changes in the costs of a providing physician and other services paid under the resource-based relative value scale.

(B) ''Hospital market basket'' means the input price index used by the Centers for Medicare and Medicaid Services to measure changes in the costs of providing inpatient hospital services provided by acute care hospitals that are included from the Medicare prospective payment system.

(C) ''Hospital market basket for excluded hospitals'' means the input price index used by the Centers for Medicare and Medicaid Services to measure changes in the costs of providing inpatient services by hospitals that are excluded from the Medicare prospective payment system.

(h) Nothing in this section shall prohibit an employer or insurer from contracting with a medical provider for reimbursement rates

different from those prescribed in the official medical fee schedule.

(i) Except as provided in Section 4626, the official medical fee schedule shall not apply to medical-legal expenses, as that term is defined by Section 4620.

(j) The fee schedules adopted pursuant to this section shall apply to all medical care, services, and goods provided after the fee schedules have become effective, provided, however, that no fee for physicians shall be lower than the Medicare fee allowed for that service in the year 2003.

(k) The following Medicare payment system components may not become part of the official medical fee schedule until January 1, 2005:

(1) Inpatient skilled nursing facility care.

(2) Home health agency services.

(3) Inpatient services furnished by hospitals that are exempt from the prospective payment system for general acute care hospitals.

(4) Outpatient renal dialysis services.

SEC. 6. Section 5307.2 of the Labor Code is repealed.

SEC. 7. Section 5307.21 of the Labor Code, as added by Section 74 of Chapter 6 of the Statutes of 2002, is repealed.

SEC. 8. Section 5307.21 of the Labor Code, as added by Section 13 of Chapter 866 of the Statutes of 2002, is repealed.

SEC. 9. Section 5402 of the Labor Code is amended to read:

5402. (a) Knowledge of an injury, obtained from any source, on the part of an employer, his or her managing agent, superintendent, foreman, or other person in authority, or knowledge of the assertion of a claim of injury sufficient to afford opportunity to the employer to make an investigation into the facts, is equivalent to service under Section 5400.

(b) If liability is not rejected within 60 days after the date the claim form is filed under Section 5401, the injury shall be presumed compensable under this division. The presumption of this subdivision is rebuttable only by evidence discovered subsequent to the 60-day period.

SEC. 10. Sections 1 to 9, inclusive, of this act shall become operative only if Senate Bill 229 is enacted during the 2003 portion of the 2003–04 regular session.

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